LEGISLATION AND PREPAYMENT FOR GROUP PRACTICE*

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COMBINED practice units, defined as units in which two or more health-care practitioners use single premises, are not new. For whatever reasons, from father-and-son joint practices to combinations devised to achieve administrative efficiency or increased professional satisfaction or both, the mechanism dates back to the remote past. These partnerships, associations, or other joint arrangements for sharing premises and overhead expenses often extended to the sharing of income and practice. Often these methods were employed to provide improved availability and accessibility of care during the absence of a particular practitioner.

Industries in isolated areas required on-site health services for occupational injuries, for the protection of employees, and for the maintenance of a healthy work force. Examples are the mining, lumbering, maritime, and railroad industries. The employer's need to recruit and maintain a steady, reliable work force required the extension of "fringe" services to the families of employees. Wherever it was feasible the employer provided, at a charge, housing, commissary (general store), and similar services for employees and families. In very isolated areas the medical units consisted of physicians employed by the industry. In less isolated areas physicians in practice provided the services and received retainer or fee-for-service payment from the employer. In all such situations the employee had a "right" to medical care as a benefit of employment.

This type of payment by the employer has come to be termed a "fringe" benefit, for it represents a form of compensation as the employee's liability for care is assumed by the employer. The health pro-

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grams of the Kaiser Foundation originated with the need of an industrial organization to provide health care for its own employees.

Employees in settled communities where such services were not usually provided by employers often used organizations such as mutual benefit associations, fraternal orders, and cooperatives, and developed plans to pay, in part or wholly, for certain health services. In some instances these organizations established facilities and employed physicians and other persons to provide services.

The development of rail transportation west of the Mississippi required the recruitment, movement, and continuing retention of work forces located in desolate and, at times, hazardous areas. Almost immediately after the construction of the railroad came the need to provide the labor force for support services as well as for the influx of new business and industry.

In the course of their westward movement the railroads established a chain of hospitals and contracted with physicians to provide care solely for their employees and for retired employees. There were no serious transportation problems, as employees could travel on the railroads without charge and hospitals were usually located at rail terminals. These facilities, staffed by physicians sometimes drawn from those practicing in the community were, and to this day continue to be, available to all employees and retired employees without charge; the railroad retains fiscal responsibility for the operating costs. This is an early example of a fully prepaid program—full payment by the employer for unlimited health care of the employees.

There are about 21 hospitals of this kind. Many are in highly populated areas such as St. Louis, Mo., and San Francisco and Los Angeles, Calif. These hospitals, intended for employees and initiated before the women's liberation movement, are not equipped to provide obstetrical, gynecological, or pediatric care. The railroad unions (brotherhoods) viewed these facilities and services as paternalism, and through collective bargaining they sought and won cash-benefit programs for employees who used outside care. Those benefit programs, which provided for cash payments toward expenses, also provided coverage for family members. In recent years the railroads have sought, with minor success, to convert their hospitals into community facilities.

This chain of underutilized hospitals west of the Mississippi is an example of early, still extant, hospital-based groups or combined prac-

tice units. These facilities are underutilized because of the absence of support from the organizations of the employees for what they regard as a fringe benefit controlled and operated by the employer. Although organizations for the employees appoint representatives to the hospital board, the age-old principle of "he who holds the purse strings" assures control by the employer.

Especially in the Mid-West and West the mechanism of the co-operative was used to help finance and provide medical services. The cooperative is the consumer. It operates economic programs which are distribution-oriented, need-oriented, and consumer-oriented. It exists solely for the interests of its members. Historically it has successfully organized and efficiently operated many types of business. Essentially, its primary purpose is to provide its members with needed products at the lowest economically practicable net cost. The founders of Rochdale Weavers Cooperative late in the 19th century formulated the principles which govern the operation of all such enterprises. These principles, which apply equally to the organization and conduct of a health plan managed by a cooperative, include: democratic association, voluntary participation, autonomous control, equitable distribution, mutuality of motivation, universal integration, evolutionary growth, and education.

Cooperative ventures have been developing plans to meet health needs. The first cooperative health plan so designated was organized in 1929 at Elk City, Okla. The plan has had a stormy existence, but it brought medical care and a hospital where they were needed.

In later years other health plans, which provided for partial or full participation by consumers, began to provide prepaid services. Two plans, the Gronp Health Cooperative of Puget Sound, Seattle, Wash., and the Community Health Association in Two Harbors, Minn., although cooperatives in the technical sense, have one important difference, which concerns the use of surplus income. This difference is described below. Except for this, all cooperative ventures provide that: membership is open to all; control is exerted by the membership; each member has one vote; the membership owns the facilities; and the associations are nonprofit.

The difference between a health-plan organization and all other cooperative ventures is the distribution of excess income or surplus. In cooperative business organizations surplus is returned to members and to customers. In the health-plan endeavors, such monies are applied

either to: a reduction of the periodic subscription charge; the addition of new services; provision of additional professional compensation; expansion of staff; or improvement of facilities and modernization of equipment. Surplus is not returned to members.

The basic characteristics of a cooperative health plan are two: the pooling of health-care needs and resources and assuring group payment for the cost of care; and an arrangement with the providers for the provision of care.

A Health Plan for Municipal Employees

In 1946 the city of New York adopted implementing legislation and acted as a pioneer in establishing an employment "fringe" which provided a medical and hospital program for municipal employees and their families. Benefits under this program began in March 1947.

The plan was conceived when Fiorello LaGuardia was mayor. It was initially intended to meet the needs of poorly paid city employees. The motivating force behind the city's action was the Municipal Credit Union, a cooperative organization for city employees. The experience of this organization demonstrated that unexpected medical expense was the most frequent cause of a demand for loans for employees. The union sought a program that would protect employees and their families against health and hospital costs through a mechanism that would guarantee care and avoid excessive expense to the employee. This objective led to the development of the Health Insurance Plan (HIP), the first community-sponsored group practice plan for prepayment in the East. Because of the limitation imposed by state statutes in effect at that time, HIP could provide only a medical services program; it was necessary for the city to contract separately with Blue Cross for hospital benefits. Employees who elected the combined coverage of HIP and Blue Cross paid approximately half the premium cost; the city made up the difference.

About 19 years later, in 1966, the employees, through collective bargaining, won full payment for a "basic" benefit package and, in addition, secured the right to choose any one of three medical programs, each in combination with Blue Cross, which continued as the carrier of the hospital insurance. In 1966 the city raised its contribution to 75%. In 1967 it paid 100% of the basic coverage premiums.

A Health Plan for State Employees

In 1957 the state of New York adopted employee health-benefit (insurance) legislation. The state civil service commissioner appointed an advisory committee of prominent community leaders and professional persons to help develop the details as to benefits and participating plans. Although the state legislation did not provide options, the commissioner exercised his administrative authority and accepted the recommendation of his advisory committee; he established a statewide program for all employees; for those employees residing in specified localities in which other coverage was available the option was given to elect a comprehensive indemnity plan—Group Health Insurance (GHI)—or a group-practice plan, HIP. Hospital benefits were contracted through Blue Cross under an experience-rated arrangement to provide uniform benefits for all employees.

A Health Plan for Federal Employees

In 1959 the United States Congress adopted the Federal Employees Health Benefits Act. For the first time a health-plan statute provided for the participation of plans differing in sponsorship as well as benefits. A major difference from the New York City and the New York State plans was the requirement that each option had to provide for both medical and hospital benefits. The federal program began on July 1, 1960, and provided that employees might elect coverage of: 1) a nationwide service-benefit program (Blue Cross-Blue Shield), 2) a nationwide indemnity program (Aetna), 3) one of a number of employee-organization plans (postal workers, etc.) or, 4) one of two categories of comprehensive health plans. This latter option included 1) an individual practice plan such as GHI in New York City, Washington Physicians Service in the State of Washington, San Joaquin and Sacramento Medical Foundations in California, etc., and 2) a prepayment group-practice plan such as the Kaiser-Permanente plan on the West Coast; the Community Health Association, Detroit, Mich.; the Group Health Association, Washington, D.C.; the Group Health Cooperative of Puget Sound, Seattle, Wash.; etc. Soon afterward California and Hawaii enacted similar statutes for state employees.

Medicare and Medicaid

The Social Security Amendments that provided for Medicare and

Medicaid (Titles 18 and 19) were enacted in 1965. A phrase which was a later addition to Section 1833 of Title 18 (Medicare) provided for the participation of prepayment organizations on a basis other than fee-for-service. This type of organization is termed a Group Practice Prepayment Plan (GPPP). For Medicare purposes it is defined as an organization that has a formal arrangement with the equivalent of three or more full-time physicians to provide certain health services, generally on a non-fee-for-service basis, to the plan's members. The term prepayment is implicit in the requirement that the members who use services have contributed, or have had payments made on their behalf in advance, toward the cost of care through the payment of premiums or dues, or that such payments have been made on their behalf. Under the GPPP arrangement with the Social Security Administration the fiscal intermediary is bypassed and the relation with the Social Security Administration is direct.

Group Practice Facilities Act

Several years later Congress enacted Title 11 of the National Housing Act, which authorized the secretary of Housing and Urban Development to insure mortgage loans to finance the construction or rehabilitation of, and the purchase of equipment for, facilities for the group practice of medicine, dentistry, or optometry. Under this act the secretary delegated the federal housing commissioner to be responsible for the conduct of the program. Technical assistance and guidance to the commissioner on the medical and health aspects of the program are provided by the U.S. Public Health Service. In the implementing regulations promulgated during October 1968, eligible group practice is defined as follows:

> An Association or group of persons with the capability and intention of making available comprehensive medical, dental or optometric care to include preventive, diagnostic and treatment services for ambulatory patients. Such services shall be provided and arranged for by the group working together as a coordinated practice. Payment for services provided by such a group may be on a "Prepayment" basis or on a "Fee-for-service" basis. An organization provides comprehensive health care under a prepayment plan when periodic predetermined payments are made to cover the costs of all or most of the services offered by the

organization. Under a fee-for-service arrangement, a patient pays a fee for each service rendered by the group.

Basic qualifying requirements for the composition of the groups are subdivided into three professional fields: medicine, dentistry, and optometry. In either case a group that meets the basic requirements may add full or part-time professionals from its own or other professional fields.

Full-time practitioners are those who provide professional services through the group arrangement as their principal professional activity; i.e., practitioners who devote at least three fourths of their professional time to caring for the group's patients. Each member of the group must be fully licensed in the jurisdiction in which the group intends to practice and must be covered by malpractice insurance.

The basic requirements for each of the three professional fields to quality for loans are:

Medicine. There must be five or more full-time physicians. At least one physician must be in general practice or in internal medicine. Further, the group must include physicians qualified in surgery and obstetrics or have arrangements for treatment of patients by such qualified physicians. In isolated or sparsely populated communities, consideration may be given to groups with as few as three physicians. This loan program is not intended to provide support for single-speciality groups. Consideration may be given on a case-by-case basis when the applicant, such as a group of internists, proposes to provide a broad continuum of health services rather than the limited service primarily restricted to referral cases.

Dentistry. There must be three or more full-time dentists with at least one of the group providing general care.

Optometry. There must be three or more full-time optometrists.

Other requirements cover:

Coordination of activity. The law specifically requires that the members of the group conduct their practices with coordinated activity. Insofar as feasible the practitioners will be required to share in the use of the technical and professional equipment and the auxiliary personnel. Clinical records are to be maintained so that they will be equally available to each member of the group. Where the practitioners are members of a partnership or other type of independent association, rather than employees of a health-care organization having a distinctly separate entity from the practitioners, the agreement must provide for

placing receipts for professional services in a common fund to be distributed according to some predetermined plan after the payment of the facility's operating expense. Income must be shared.

Auxiliary staff requirements. It is further required that the group must maintain an appropriate combination of licensed ancillary personnel adequate to provide supporting service to the professional members. Staff members must be properly qualified and licensed whenever state or local laws require such licensing. Provision must be made for competent management and administration of the group's business affairs.

Medicare: the Group Practice Prepayment Plans

Public Law 89-97 created Medicare and Medicaid. In its early drafting the intent under Title 18 (Medicare) was to establish a hospital program for the elderly. However, adverse congressional reaction to Elder Care, which was proposed by the American Medical Association, resulted in the inclusion of Part B, Title 18, the supplementary voluntary medical insurance program. This program (patterned after the commercial carriers' major-medical benefit plans) initially provided only for a universal form of major-medical coverage ($50 annual deductible, thereafter 80% payment toward a physician's charges). Concerted action in favor of existing group-practice plans supported by labor succeeded in a last-minute amendment, and the proposed provision, "payment of benefits," was extended to provide the following:

> Except that an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80% of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80% of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20% of such reasonable cost plus any amounts payable to them as a result of subsection (b).

The intent of this amendment, as supplemented by congressional legislative history (and noted in committee hearings and the *Congressional Record)*, was to permit group-practice plans to be classified as eligible under this prepayment concept. However, reasonable cost as defined in section 1861—(V)-(1) required that the regulations to be issued by the secretary be based on principles generally applied by na-

tional organizations or established prepayment organizations (which have developed such principles). This definition of reasonable cost was not amended to provide for the prepayment plans of group practice. The statute provides that the regulations shall: 1) take into account both direct and indirect costs of providers of service in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established will not be borne by individuals not so covered and that the costs with respect to individuals not so covered will not be borne by such insurance programs; and 2) provide for the making of suitable retroactive corrective adjustments where the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive. Thus costs mean actual outlays and incurred expenses, which foreclosed GPPP's from benefiting from savings due to coordination of care, reduced use of inpatient facilities, etc.

The enacted statute which provided for GPPP's in the payment-of-benefits provision was not implemented in the remainder of the statute's provisions relating to the establishment of reasonable cost. (Reasonable-cost rules for hospitals were based on principles established by the American Hospital Association and applied by the Blue Cross plans.) The rules for physicians' charges were based on definitions developed by organized medicine and applied by Blue Shield. Wilbur Cohen, Secretary of the Department of Health, Education, and Welfare (HEW), then had the administrative responsibility to interpret the application of the amendment payment of benefits (Section 1833) on all other provisions and to resolve the conflicts. Two distinct areas needed resolution. Foremost was the basis of participation for the "hodgepodge" of types of prepayment plans that had won the right to participate. The other was to evolve regulations* that would encourage participation in the plan and meet the intent of the statute: namely, to provide comprehensive care at reasonable cost. The goals include coordinated services, improved availability, and accessibility and quality of care.

Health Maintenance Organization

In 1970 the Ways and Means Committee of the House of Repre-

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sentatives prepared the Social Security Amendments of 1970 and developed a new term for group practice. The name is Health Maintenance Organization (HMO). Under the proposed amendments, individuals eligible for coverage under both parts A and B of Medicare would be able to choose a new part C and have their care provided by a HMO (a prepaid group-practice health plan or other type of capitation plan). The intent of the government would be to pay for the coverage on a capitation basis not to exceed 95% of the cost of Medicare for fee-for-service benefits had the beneficiaries not been enrolled with the Health Maintenance Organization. The proposed effective date for this change is January 1, 1971. On page 52 of the committee report of the house bill HR-17550, the committee explains its reasoning by noting that reimbursement to group-practice plans must provide financial incentives to control utilization. The report states:

> The organization will be encouraged to manage its resources and provide a level of service within a predictable premium income; extensions and improvements in service could thus also be provided to beneficiaries from utilization and other savings that the organization may be able to make within resulting income.

The HMO is described in this report as one which provides:

> 1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis; 2) all the services and benefits of both the hospital and medical insurance parts of the program; 3) physician's services, either directly by physicians who are employees or partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services on the basis of an aggregate fixed sum or on a per capita basis. (The group of physicians which has the arrangement with the health-maintenance organization could, in turn, pay its physician members on any other basis, including fee-for-service.)

The committee proposes that HMO's be encouraged for Medicaid and notes the following:

> Moreover, it is expected that the Department of Health, Education, and Welfare would use the provisions of medicare law and regulations for health maintenance organization, to the extent appropriate, in regulations for health maintenance organizations,

to the extent appropriate, in regulations dealing with similar coverage under the medicaid program.

A Giant Step?

The October 1970 issue of *Group Health and Welfare News* announces "New Law Permits FEHB Carriers to Issue Group Contracts, Authorizes Prepaid Plans to Expand Cover Areas."* The article says of the law that: "It will also permit existing prepaid group practice plans to provide services to their members outside their immediate area. For example, HIP could provide services in New Jersey and Group Health Association of Washington could do likewise in Virginia."

This new law (Public Law 91-525) originated with the amendments to the Public Health Service Act to provide for the continuation of the Regional Medical Programs. The initial proposal was passed by the House of Representatives on August 12, 1970. While under consideration in the Senate the bill was amended to include a new Title 4 "Authority for Group Practices." This modification, introduced by Senator Edward M. Kennedy (Dem., Massachusetts), was designed to enable prepayment group-practice plans to expand into states in which there were legal and other barriers to such programs. The report of the Committee on Labor and Public Welfare† states the intent of this amendment as follows: "There are many states today where this and other types of innovation by the private health sector could not be undertaken, even though physicians, medical schools, consumers, nonprofit organizations, cooperatives and private insurers would be ready and willing to develop them, given the opportunity. Title IV . . . is intended to make the opportunity available."

Under this new law, carriers, including prepayment plans, that provide benefits to federal employees and retired employees can extend their areas of coverage and can issue contracts for group-practice care to other persons. The secretary of HEW is authorized to establish minimum requirements as to the professional composition of such group practices and the minimum range of services to be available and provided.

The secretary's authority is limited to qualified carriers who partic-

**Group Health and Welfare News*, p. 2, October 1970. Group Health Association of America, Washington, D.C.

†Senate Report 91-1090 (S.3355).

ipate in the provision of coverage under the Federal Employees and Retired Employees Health Benefit Acts. For such carriers, the secretary can authorize issuance of contracts to any person (whether a federal employee or dependent) for prepaid comprehensive medical services provided by a group-practice unit or organization defined as follows: ". . . a non-profit agency, cooperative or other organization undertaking to provide, through direct employment of, or other arrangements with the members of a medical group, comprehensive medical services (or such services or other health services) to members, subscribers or other persons protected under contracts of carriers."

The law provides that the states retain responsibility for: 1) regulating the amounts charged for contracts, 2) the manner of soliciting and issuing contracts or for regulation of carriers issuing such contracts in any manner not inconsistent with the provision of this section.

The provisions of this law relate only to the extension of group-practice units to provide prepaid care and do not seem to affect other state requirements such as licensure. The secretary of HEW's regulations should clarify the basis for accomplishing the law's intent.

It is expected that any portion of Public Law 91-515 which supersedes state statutes will be tested in the courts.